

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-036547

5192

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

FILED OCT 7 1963

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Jackson</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <i>Kansas city</i>		c. CITY OR TOWN <i>Kansas city</i>	
Length of stay in 1b <i>22 yrs</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>General Hospital</i>		d. STREET ADDRESS (If outside, give location) <i>1016 Forest</i>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <i>HARVEY F. WARNER</i>	4. DATE OF DEATH Month Day Year <i>9-20-1963</i>
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5. SEX <i>male</i>	6. COLOR OR RACE <i>wh</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>1-13-1922</i>	9. AGE (last birthday) <i>41</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>taxi driver</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>---</i>	11. BIRTHPLACE (City and state or country) <i>Waverly, Kans.</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
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13a. FATHER'S NAME <i>Harvey C. Warner</i>	13b. MOTHER'S MAIDEN NAME <i>Martha Titterton Billie</i>	14. NAME OF HUSBAND OR WIFE <i>Billie Warner</i>
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15. WAS DECEASED MEMBER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>	16. SOCIAL SECURITY NO. <i>---</i>	17. INFORMANT <i>Billie Warner</i>	Address <i>1016 Forest</i>
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Block + Hemorrhage resulting from stroke & swelling of chest</i>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>Star hand of fist</i>
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20c. TIME OF INJURY Hour a.m. p.m. <i>9-20-63</i>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Street</i>	20f. CITY, TOWN, OR LOCATION <i>Kansas city</i>	COUNTY <i>Jackson</i>	STATE <i>Mo</i>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <i>Kansas city</i>	COUNTY <i>Jackson</i>	STATE <i>Mo</i>
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21. I attended the deceased from _____ to _____ and last saw him alive on _____	Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Deedee or title) <i>Dr. C. Keating</i>	22b. ADDRESS <i>6623 Pershing Ave</i>	22c. DATE SIGNED <i>9-21-63</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>9-24-1963</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Waverly Cem</i>	23d. LOCATION (City, town, or county) (State) <i>Waverly, Kans.</i>
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24. FUNERAL DIRECTOR <i>Lassantino Bros</i>	ADDRESS <i>Kc. Mo</i>	25. DATE RECD. BY LOCAL REG. <i>9-23-63</i>	26. REGISTRAR'S SIGNATURE <i>Bessie Smith</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF C. Keating

DATE AMENDED

VS 300
Rev. 4/59

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2 3/68

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4 0

5 1

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9 982X

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12 51-3

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

St. Passantino

Licensed Embalmer No. 4554

P. O. Address K C Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT; he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.